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This paper deals with the experiences of two psychiatric consultants at four public elementary schools in the central Harlem area of New York City. Administrative conflicts resulted in the abandonment of the consultation project at one school. In the remaining three schools the consultants provided help as specifically requested by the school guidance counselors. In one school the consultants supervised the guidance counselor in conducting group therapy sessions with seven 9-year-old children. In the other two the consultants conducted group discussions with counselors and teachers. The results of the project indicate that psychiatric consultants can help the school staff to cope with inappropriate attitudes and with conflicts among themselves. (LB)

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PSYCHIATRIC CONSULTATION WITH PUBLIC SCHOOLS IN AN UNDERPRIVILEGED NEIGHBORHOOD

Robert B. Sussman, M.D. and Sheldon Zimberg, M.D.

INTRODUCTION

In recent years mental health consultation to schools has become an increasingly important subject of discussion among educators and mental health professionals. Educators have recognized the importance of providing support to classroom teachers in dealing with management and learning problems through the use of guidance counselors, educational psychologists, and by referring children with problems to child guidance clinics outside the school system. This interest has also resulted in the increasing development of mental health programs within school systems and a closer collaboration between educators and mental health professionals.[6,10,17,18,21,26]

The techniques and dynamics of mental health consultation with educators have been elucidated by Caplan and Berlin[4,7] (1956), Bernard,[5] Pearson,[22] Neubauer and Beller,[20] and Hirning[12] (1958), Caplan[8] (1959), Wylie and Sills[25] (1960), Kipfer et al,[15] and Klein and Lindemann,[16] (1961), Berlin,[2] Kazanjian et al,[14] and Hollister[13] (1962), Gluck[9] (1963), Berlin[3], (1964), and more recently Millar[19] (1966). There has

been increasing involvement of psychiatrists outside school systems in this work. It can be expected that the regionalization and greater local responsibility for mental health care that will result from the establishment of community mental health centers will accelerate the involvement of psychiatrists and other mental health professionals with schools in the catchment areas of these centers. The variety of roles that a psychiatrist can be called upon to play was discussed in a report of the Committee on Preventive Psychiatry of the American Psychiatric Association (1964)[1]. These roles include clinical consultation to the school health department, problem-centered consultation to guidance personnel, direct psychiatric consultation with children, the participation of the psychiatrist in a child guidance clinic associated with the schools, research activities, clinical services to the school staff, consultation to teachers and/or administrators, mental health education for school personnel, and program-centered consultation for administrators.

The need for help in the form of mental health consultation as well as additional educational and clinical services for school personnel in disadvantaged Negro neighborhoods becomes apparent when one observes the effects of <u>de-facto</u> segregation[11], socio-economic de-

privation, and family disruption on children's ability to learn; and the resultant pressures on teachers faced with these problems. Such a conclusion was reached in a Board of Education report based on the study of three Harlem schools in 1947.[23] A survey conducted by the New York City Bureau of Child Guidance[24] supported the need for increasing the amount of mental health consultation to the schools. This paper is a description of two psychiatric consultants' experiences in schools operating under these conditions.

Description of the Project

Two psychiatrists carried out the psychiatric consultation program with four public elementary schools in the Central Harlem area of New York City. The psychiatrists were post-graduate fellows in Columbia University's Division of Community Psychiatry. As part of the field work in Community Psychiatry, they were placed with the Division of Child Psychiatry of Harlem Hospital Center, which offered an ongoing program of consultation to the local schools. Consultation was to be offered on a weekly basis to two schools, bi-weekly to the other two during the Spring term of 1966. The consultative relationship with one of the schools was abruptly terminated at the beginning of the project for reasons to be discussed below.

The initial contact at the schools was with a guid-

ance counselor at one school and principals at the other three. The psychiatrists worked with the senior guidance counselor at the schools, and the type of consultation initially provided was based on the particular need expressed by the school personnel. One school professional requested clinical supervision for herself in conducting group psychotherapy with nine year olds; another requested meetings with beginning teachers to discuss their problems in the school; at the third school it was requested that consultation be made available to the teaching staff and other interested staff members; the fourth school wanted consultation for teachers and some professionals from the clinical arm of the Board of Education who were working with specific children in the school.

The Schools

School A: At school A the guidance counselor said she wanted to learn about groups and groups methods. She felt this was the way of the future and she wanted to keep up with the times. She felt some vague pressures on her from within the guidance profession that she work with groups. To this end she had taken a course at a local college in group therapy. She said that she was told that the only way really to learn was to run a group of her own. She wanted the psychiatrist to be a co-therapist in running a group and to act as her supervisor. She had already selected the group members;

seven Negro children, age nine. There were four boys and three girls. All were thought to have normal intellects but were doing poorly in school. She did not consider any of them to be really sick, and they would not normally be referred for psychiatric treatment.

All came from broken homes, except one boy. He came from a religious, strict family, not on welfare, who were bound and determined to make it on their own. He stuttered, was tense, quite shy, and non-aggressive. The others were all aggressive, restless children who did not listen in class. The psychiatrist agreed to assist her in this, but with much doubt about the wisdom of such a plan; in time it was hoped that a more helpful approach would evolve.

The first problem that was considered with the psychiatrist was to select a suitable room to hold the sessions. Two rooms were available. One was the counselor's office, but this was quite small. The other was a large room, but was used on occasion as a teachers lounge. There was the possibility of being interrupted there. The lounge was finally selected because of its size. Meetings commenced the next week.

The group was initially organized around a box game that all would play at the start of the meeting. However, this activity became disorganized as the children refused to remain seated at the table. They would run around the

room, hitting each other and throwing things. The guidance counselor was upset at this, partly because the children were not taking her directions, and partly because she feared they would mess up the room or hurt each other. It developed that she was afraid of the criticism of other teachers if they should come into the room and see the mess the children were making.

For some weeks the children continued with this behavior. Gradually they came to write on the blackboards. This started off with writing their names, then dirty words and comments about each other and curses. Then they began to give themselves arithmetic and spelling problems in competition with each other and finally asked both the guidance counselor and psychiatrist to give them problems to do. This was where they were at the close of the term.

There was real improvement in the school work and demeanor of the shy, stuttering child. No significant changes were reported in the others outside the group meetings.

The guidance counselor was bewildered by the activities in the group meetings; she was quite impressed that the children did not actually hurt each other during the early meetings. Toward the end she was pleasantly surprised at the children's desire to write on the boards and compete with each other in this way. She was encouraged by the psychiatrist to go along willingly with this and

do some teaching. Problems arose concerning her relationship with other school personnel. Various persons would come into the room during the meetings and she could not bring herself to ask them to leave for fear of offending them.

The psychiatrist was able to help her see that she felt isolated in the school. She said she could not work with the other guidance counselor because he had no formal training in the field, and that the other teachers gave her no cooperation. She saw herself as the only one in the school who really cared about the children. But she felt she didn't know what to do to help them. She had thought that groups, like the one she started, were the best answer and that, in this way, she would be using the most modern techniques to provide help. However, she finally decided with the psychiatrist that she must re-evaluate her situation in the school to see what other approaches might be open to her. She decided she would discuss this further with the next psychiatric consultant she was to have in the Fall term rather than continue with group therapy. On that note, the consultations at the school ended for the term.

School B: At school B there were two guidance counselors who worked together. Both were Negro women, about forty years old. One was dynamic, and forceful, the other was

more withdrawn and retiring.

They discussed freely with the psychiatrist the problems that the pupils had in school. These problems centered about the difficult and unstable home situations. The school had tried various programs to help--after school study sessions, emphasis on Negro culture and history in the United States, and attempts to build up pride in being Negro. However, relations between the school and the parents of the children were very bad, and the counselors refused to discuss this situation. They did say it was because of someone at the school who had precipitated difficulties, but nothing could be done about it.

The guidance counselors had in mind that the psychiatrist would work with a group of five teachers who had just begun to teach that term; and the psychiatrist was agreeable to this arrangement. It was decided that guidance counselors would sit in on the meetings.

The early meetings were centered on the problems of discipline and class control. Gradually this was replaced by discussions of individual children and how best to reach them and get them involved in school activities. The members of the group would present anecdotal material about the children and using family background information supplied by the guidance counselors,

the psychiatrist and teachers together would try to determine why the child behaved as he did, and what was the best way to handle him. There was a tendency for the guidance counselors to give specific suggestions and advice to the teachers. This tended to cut off the discussions prematurely. The psychiatrist was unable to prevent them from doing this or get them to see what they were doing. Repeated requests were made by the counselors that the psychiatrist give more clinical psychiatric talks and evaluations of specific cases. This was resisted by and large.

At the close of the term the counselors felt somewhat unsatisfied by what had been accomplished by the sessions. The teachers, however, had been quite involved in the sessions and saw them as a good thing. The psychiatrist felt that in spite of the open and forthright atmosphere that the guidance counselors were trying to create, they actually had repressive and inhibitory influences on these young teachers. He tried to counter these influences by promoting more profound discussions between them.

School C: The initial contact with this school was with the guidance counselor. At the first meeting with the guidance counselor and acting principal, the time, place and format of the consultation sessions were de-

cided. The school personnel wanted lectures on a variety of important areas presented by the psychiatrist to an open ended group of teachers during the lunch hour, once a week. Release time from classes could not be provided by the school since there would be no one to cover the teachers' classes.

The psychiatrist believed that lectures would not be particularly helpful, but initially went along with the request. It was felt that in this school as in school A the teachers in the group would make their needs known, and a more helpful approach involving group process would evolve.

The first group meeting involved a discussion by the psychiatrist of the "Impulsive Child". The psychiatrist's discussion was soon punctuated with many questions from the teachers who made reference to problem children in their classes. The psychiatrist responded to these questions by drawing out the teachers in order to get more information and a feeling for the problems encountered by the teachers. The next few sessions similarly involved the discussion of problem children.

After several sessions it was decided to have discussions centered on a particular child. Hopefully, generalizations could be applied to similiar difficulties faced by other teachers.

The teachers at first pressed the psychiatrist to

provide solutions for the problems presented in the form of requests for management prescriptions. The psychiatrist explained that he was not an expert on education or classroom management; the teachers were the experts in these areas. He stated that his role was to explore with the teachers some of the causes of difficulties presented by some of the children and to increase their understanding of human behavior and feelings so that they might be in a better position to deal with their own feelings and with the problems that they faced.

Some teachers were able to accept this position but others were not, and at times would continue to ask "what should I do"? Various teachers began to discuss the ways they had dealt with similar problems, and the guidance counselor often contributed his understanding of the problem and some ways of dealing with it. Thus, an open discussion atmosphere developed in which teachers with more experience in some areas were helping those with less experience. The guidance counselor was able to discuss at length his involvement with the child, bringing to bear additional information about the family and home life of the child. After a number of weeks the teachers were expressing feelings about the conditions under which they worked, and the many children with problems they had to handle in the classroom. The teachers were able to be more open with themselves and their colleagues

in the group where there was sharing of common problems and mutual helping had been established.

The psychiatrist avoided any attempt at interpretation of the teacher's behavior or feelings, and discouraged discussion of personal problems in order to avoid a group therapy situation. At times, this was a difficult task since many aspects of a therapy group developed, including positive and negative transferences to the psychiatrist. The group did have therapeutic aspects, however, in the form of the participants' better understanding that the negative feelings they had were shared by others, and that the problems that they faced were not a reflection of their being bad teachers.

At times the psychiatrist would raise questions concerning what additional information would be helpful in understanding a child's problem, and possible relationships of home situation to school problem. Such dynamic relationships were not made in technical terminology, but in terms of understandable requirements of healthy development.

A chronological review of a child's problem could be done since teachers from several grades were present, some of whom had the child in their class when he was younger. In addition, the differing reactions to a male and female teacher that was observed at times

was helpful in explaining aspects of the transference phenomenon.

This open discussion of a child's problem raised the issue of confidentality. Should teachers be made aware of home situations of their pupils? Should family history such as an alcoholic father or promiscuous mother be discussed by teachers whose role is basically to teach, and who might use such information against the child? This issue was discussed in the group, and the psychiatrist stressed the need for confidentiality. The group felt that teachers as professionals were responsible individuals whose interest was to help children. Thus, a definition of a teacher as a potentially helping person, not simply as an imparter of knowledge emerged. However, this complex issue was not adequately resolved. The psychiatrist agreed with the teachers, but he felt that probably only a minimum of family history was necessary, and then only in general terms, to the understanding of the problems presented by the teachers; and care should be taken to avoid gossip and misuse of such information.

A number of types of problems in the classrooms were discussed including impulsive children, passive and defiant children, underachieving children, and the child who returns to school after institutionalization. Also discussed were problems of curriculum content

such as the place of Negro History and current Negro activities in the schools, the issue of busing of children to achieve integration, and some effects of de-facto segregation on the children. The group was composed of both Negro and white teachers, and the weekly sessions provided an opportunity to discuss some of these complex and emotion-laden issues.

Toward the end of the project, questions concerning administrative procedures and services that could be helpful to the children were discussed. The need for more junior guidance classes and guidance counselors, smaller classes, and more teachers' aides became apparent. The value of the separate schools for emotional disturbed children was explored. The relationships of the classroom teacher to the school administration was raised, and the question of whether the principal should always back a teacher who was having a dispute with a parent was considered.

The group consultation sessions underwent an evolution both in the format of the sessions and in the perception of the psychiatrist by the group. The psychiatrist was at first perceived as having all the answers and as being an all around expert. In time the teachers realized that the psychiatrist could learn from the group meetings as well as they themselves, and a more collaborative effort emerged. A forum of professional exchange between teachers and the guidance counselor concerning

common problems and feelings developed out of the original plan of having the psychiatrist give lectures. The focus of the discussions swung away from individual problems of children to ways of providing help to the children in terms of administrative changes and increasing services to the school. The initial feelings of frustration and resignation that many of the teachers demonstrated in talking of their overcrowded classrooms, and the difficult children who showed little inclination to learn changed to a determination to try to get the needed additional services for their school. In addition, the teachers who participated in most of the sessions seemed to better understand the relationship between home problems and difficulties the children showed in school. The time of the project was too short to have determined a significant effect of the group discussions on attitudes and behavior of the teachers in the classroom. However, the way the children were discussed toward the end of the project was different in terms of greater freedom of expression of the teachers' feelings, a more optimistic outlook, and understanding that problems in the classroom did not mean that they were bad teachers.

School D: School D was selected to be part of the consultation project because of its proximity to the hospital, a number of pupils from the school were being treated at the child psychiatry clinic, an after-school

program conducted by the Division of Child Psychiatry was based in the school, and the interest which was expressed by the principal. A conflict had developed between the school administration and the Division of Child Psychiatry over the school's tendency to suspend children with behavior problems, even some who were in treatment (a problem that exists with a number of schools). It was hoped that a collaborative relationship could be developed that would help the school keep the children in the classroom, and possibly decrease the number of referrals through the provision of psychiatric consultation for the school personnel. However, the project did not get off the ground and was cancelled after the first meeting with the principal.

Soon after the psychiatrist had discussed his involvement in the school with the principal, a jurisdictional dispute developed within the school concerning the psychiatrist's role. This dispute resulted in the abandoning of the psychiatric consultation project by the school. Such problems are not uncommon in consultative situations and indicates the importance of the consultant understanding the dynamics of the organization in which he plans to be involved. Continued discussion with the principal and other school personnel alleviated the problems to some extent and resulted in the acceptance of a

psychiatric consultant for this school beginning in the Fall of 1966.

Discussion

We have recounted the experiences of two psychiatric consultants who were involved with four public elementary schools in the Central Harlem area of New York City. In one school, where the psychiatrist came with a specific point of view and task to accomplish, that of reducing psychiatric referrals to the local hospital, and altering administrative attitudes toward school suspensions, various counter pressures and conflicts forced him out of the school.

In the other three instances his primary obligation was to relate well to the person who has called him in, and be open to all variety of suggestions. For the sake of maintaining a good relationship he may have to do things he has grave question about; but he then tries to move the situation onto more stable grounds. Thus, in the school where group therapy was done with the pupils, the consultant eventually was able to get the guidance counselor to see the broader aspects of her involvement in the school and begin to understand that there might be better ways to help the children. In the other two instances the psychiatrist was initially forced into an omnipotent position. The

remainder of the term was spent in trying to form a more workable relationship with the guidance counselors and teachers which could be of greater benefit to the teachers in their day to day classroom activities.

In ghetto areas like Harlem there is great community pressure exerted on the schools. Staff may be pushed into inappropriate attitudes, and conflicts may be created between the school and the public, as well as between various members of the staff. This is not helpful to the children. The psychiatrist can assist by helping staff to cope with these pressures and thereby allow them to use their own professional training and background to the best possible advantage.

The results of this project demonstrated that it was possible for psychiatric consultants to provide help to school personnel in three out of four schools that were involved. Although limitations were initially imposed on the psychiatrists, they were able to modify the consultees' attitudes so that a more useful consultation situation developed.

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